STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR AND ENONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION

Bulletin 2009- 07 -INS

In the matter of

Service area expansion requests submitted by health maintenance organizations serving Medicaid members

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Issued and entered
this 24th day of February 2009
by Ken Ross
Commissioner

Pursuant to Section 3509(3) of Public Act 218 of 1956, MCL 500.3509(3), a health maintenance organization (HMO) seeking to change its approved service area is required to submit an application to the Commissioner of the Office of Financial and Insurance Regulation (OFIR).

Section 3509(3) also requires the Commissioner to specify the information required to be in the application to change the applicable service area. While this information is clearly specified on the application for licensure located on OFIR's website and the instructions located within the System for Electronic Rate and Form Filing, HMOs serving Medicaid members (Medicaid HMOs) indicate additional specificity on criteria and factors reviewed and considered by OFIR would assist in preparing the service area approval requests, in particular as they relate to OFIR's review of requests to expand partial county approval to encompass full county approval.

This bulletin provides the basic guiding principles and factors that OFIR utilizes when considering whether to grant a Medicaid HMO's application to change/expand an applicable service area – whether expanding a partial county to encompass an entire county or to garner approval for a new full county.

GUIDING PRINCIPLES

In determining whether a Medicaid HMO's application for a service area expansion to cover an entire county should be recommended for approval, OFIR considers all of the following factors:

1. Demonstration of an adequate contracted provider network (including primary care physicians, specialists, ancillary providers, pharmacies and hospitals). The applicant must be able to provide access and availability to covered services promptly, appropriately and without unreasonable delay. MCL 500.3513 and MCL 500.3530.

2. The enrollment projections for the first 12 months and second 12 months during which the Medicaid HMO will be operating within the requested area/county.

3. Evidence that the addition of the projected enrollment for the requested area/county will not negatively impact the financial condition of the Medicaid HMO.

4. The existence of an additional contracted provider network in a county adjacent to the requested area/county.

5. Proximity to contracted care providers – whether a particular township located within a requested area/county is within 30 miles or 30 minutes travel time[1] to the following facets of the provider network: primary care physicians, specialists, ancillary providers and pharmacies.

6. Proximity to contracted hospitals – whether a particular township located within a requested area/county is within 30 miles or 30 minutes travel time to a contracted hospital or, if a particular township is located within a requested area/county that is considered rural by way of reference to the United States Office of Management and Budget criteria for metropolitan and micropolitan statistical areas[2], whether the closest contracted hospital is within 45 miles or 45 minutes travel time.

7. If a Medicaid HMO has 90% or more of all townships within a requested area/county, a majority of the members it serves are located in these townships, and no outstanding township within a requested area/county is more than 45 minutes travel time from a contracted hospital, then the guiding principle on proximity shall have been met.

8. Information reported by an HMO on its FIS 320 HMO Inpatient Discharges and Benefit Payout Report regarding the use of non-contracted versus contracted hospitals in a county.

9. Any circumstances involving a combination of the above guiding principles.

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[1] *In all cases, travel time is calculated by OFIR using the Michigan Department of Transportation-statewide proximity analysis to confirm the travel time projected by the Medicaid HMO. OFIR may consider travel times calculated using another mapping source provided it utilizes accurate transportation networks within a specific county.*

[2] *OFIR considers both non-metropolitan areas/counties and micropolitan areas/counties to be within the definition of rural under the United States Office of Management and Budget criteria.*

To the extent a Medicaid HMO cannot meet each of the guiding principles set forth above with respect to any townships within a requested area/county, the Medicaid HMO may provide additional justification for OFIR's consideration, narrative or otherwise, which may include the following:

1. The Medicaid HMO may demonstrate through referral patterns that the contracted physicians possess a clear preference for a contracted hospital over a closer non-contracted hospital.

2. The number of projected members in the outstanding township(s) within the requested area/county.

3. Number of annual access and quality care complaints the Medicaid HMO has received from members residing in the outstanding township(s) within the requested area/county.

4. Annual HEDIS scores relating to access to care and quality of care.

5. The transportation provided by the Medicaid HMO to its members residing in the outstanding township(s) within the requested area/county – specifically, the type of transportation being provided by the Medicaid HMO to ensure its members have timely access to health care services.

6. The Medicaid HMO provides written attestation that it has attempted to contract with the closest non-contracted hospital(s) but has been unable to do so, along with a narrative as to why it was unable to contract with a particular hospital. If other Medicaid HMOs have contracted with the hospital, it is important for OFIR to understand why the requesting Medicaid HMO is unable to contract with that particular hospital. (Example of some reasons for the inability to contract: the hospital will not contract with any Medicaid HMO or will only contract with one Medicaid HMO with which it has a business relationship). Documentation must be provided upon request.

7. Any other relevant information which would benefit the Commissioner's assessment of a member's ability to access and the general availability to covered health care services within the outstanding township(s) within a requested area/county.

8. The length of time the Medicaid HMO has been operating in the outstanding township(s) within the requested area/county.

The guiding principles set forth in this bulletin apply to the Office of Financial and Insurance Regulation's review of all Medicaid HMO service area applications, whether requesting to expand a partial county to full county approval or requesting to expand into an entirely new full county.

Any questions concerning this bulletin should be directed to:

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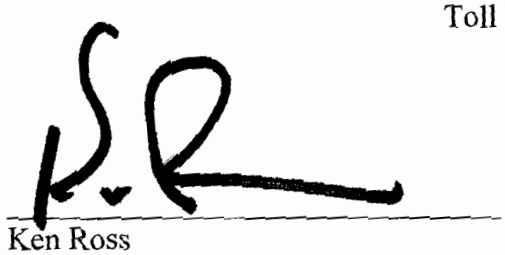

Ken Ross
Commissioner